PRINTED: 02/06/2015

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 01 B. WING HAL045093 01/23/2015 VAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3851 HOWARD GAP ROAD CARILLON ASSISTED LIVING OF HENDERSON HENDERSONVILLE, NC 28792 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACYION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) C 000 Initial Comments C 000 Report of Biennial Construction Survey by Dennis Harrell and Bob Getchell on 1-23-2015. CONSTRUCTION SECTION Records indicate this facility was first licensed or submitted for licensure on or about 7-28-2000, for 96 beds including 24 Special Care beds. Based FEB 27 2015 on the above information, the facility is required to RECEIVED meet the 1996 Rules for the Licensing of Adult Care Homes (Homes for the Aged and Family Care Homes); the applicable portions of the 2005 Rules for Adult Care Homes of Seven or More Beds; and the 1996 North Carolina State Building Code Section 409.1- Institutional Occupancy (Group I) Unrestrained. C 189 Building Equipment Maintained Safe, Operating C 189 SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F ,0311 OTHER REQUIREMENTS (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities. This Rule is not met as evidenced by: Based on observation the required one-hour. fire rated walls and/or ceilings were compromised in several locations. Holes and penetrations that are not sealed with materials approved for use in one-hour fire rated construction and inoperable ceiling radiation dampers present the possibility that a fire that begins in one space can quickly spread to other areas of the facility. Findings include: iston of Health Service Regulation ORATORY DIRECTOR'S OR PROVIDERSUPPLIER REPRESENTATIVE'S SIGNATURE (XX) DATE OFFICATE DIRECTOR OF MainteNANCE

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Division	of Health Service Re	egulation			r Ordin	MITHOTES
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/BUPPLIER/CLIA (DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDING: 01		COMPLETED	
		HAL045093	B, WING		01/2	23/2015
IAME OF	PROVIDER OR SUPPLIER	SYRPETAD	DRESS, CITY.	STAYE, ZIP CODE		
		3851 HOV	VARD GAP I			
CARILLO	ON ASSISTED LIVING	OF HENDERSON	BONVILLE, I			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF COR			
PRÉFIX		MUST BE PRECEDED BY FULL. SCIDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP		DATE
17(3	The state of the s	ou seem in the set of the seem	TAG	DEFICIENCY)	TOPLIC	1.02
C 189	Continued From	1	C 189			
0 108	Continued From page 1		C 169	C189		
	a. Unsealed penetration at a conduit in the Building Systems room. b. One listed ceiling radiation damper in the			1a) Departmention in Building Custon		1 1
				1a) Penetration in Building System	ms	
		tion in the kitchen was tied		Room has been Firecaulked		
		npers that are held open with		b) New Evenble (int has have		' I
	means other than a	manufacturer's approved		b) New Fuseable Link has been		
	_	se properly in the event of a		installed to Fire damper in the ma	ain	
- 1	fire.	idor celling pear room R1		Dining Room		
	c. Crack in the corridor celling near room B1. d. Unsealed wire penetration in closet off the Dining room. e. Hole in celling by the exit light at room D9.			616		
				C) Crack has been sealed near B1		
				d) Wire Penetration in closet in D	Ining	1
		utcheon was missing or not		·	ining	
	protection in C Hall I	eiling complete the one-hour		Room has been Fire caulked		
. 1	proteotion in o mail	Diring rount.		e) Hole has been sealed near by e	wit	
- 1		ation, the building was not		,	AIC	
		manner because of		light at D9		
- 1	cross-corridor doors not latching properly. Cross-corridor doors that do not latch when			f) Escuteon has been reattached to	to the	
		alarm system present the		ceiling in Chall Dining Room		
-		nd smoke may not be		centing in cried bitting riborn		
	contained in the compartment of origin. Findings include: a. The automatically closing cross-corridor doors					
				2a) Cross Corridors at Beauty Sale		
- 1		near the Beauty Salon are		have been adjusted to close and	latch ·	
1	equipped with latchir	ng hardware. One leaf of		properly when Fire Alarm activat	ed	
		atch when activated by the		and verified by CDoM	- 1	
- 1	fire alarm system. b. The automatically closing cross-corridor doors at the smoke barrier near room B1 are equipped					
				 b) Cross Corridors at B1 have bee 	n	
	with latching hardwa	re. One leaf of these doors		adjusted to latch and close prope	rly	
		ctivated by the fire alarm		when Fire Alarm has been activat	ed	
- 1	system'		- 1	and verified by CDoM		
	3. Based on observa	ation, the battery powered			1	- 1
Ì		e corridor near room A14		3) Emergency Light at A14 has be	en	
- 1	would not work when	tested. Battery powered		replaced and working properly	1	
	emergency lights tha	t will not work properly for at	- 1		- 1	- 1

least 90 minutes could endanger the residents

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Division of Health Service Regulation													
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED							
				HAL045093		e. WING		01/	23/2015				
NAME OF	PROVIDER OR SUPPLIER	ธา	REET AD	DRESS, CITY.	STATE, ZIP CODE								
GARILLO	CARILLON ASSISTED LIVING OF HENDERSON 3881 HOWARD GAP ROAD												
		н	ENDER:	SONVILLE,	NC 28792								
(X4) ID PREFIX YAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE COMPLETE							
C 189	Continued From page 2			C 189			,						
	and staff.		- 110										
	anu statt.												
	4. Based on observ	ation, the building was	not										
	meintained in a safe	manner by not properl	v I										
	handling medical oxygen cylinders. This could affect all residents; staff and visitors if cylinders fall, breaking their valves, propelling the cylinder				A) The Large Courses Tools to		1 1						
					4) The Large Oxygen Tank has been								
	and turning it into a	aives, propeiling the cyl dangerous projectile.	ndel		relocated and secured to the floo	ras							
	Findings include:				required and verified by CDoM								
1	A large medical oxy	gen cylinder with an atta	ched			1							
	stability base was st	tored in a closet in B Ha	·				1 1						
- 1		ox of files and leaning se al 60 that is was likely to					1 1						
	acgioco nom vento	al do that is was likely to	idii.		,								
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